TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Forth Worth

Respondent Name
Liberty Mutual Fire Insurance

MFDR Tracking Number
M4-17-3276-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 07, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the applicable Texas fee schedule the correct allowable would be per the DRG 494. The allowable for this DRG per the Medicare is $10,135.40, we have also attached the print out for your review from the Medicare price program. The correct allowable would be at 143%, making the allowable at $14,493.62. Based on their payment of $14,454.08, there is an additional allowance of $39.54 still due at this time."

Amount in Dispute: $39.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim.

A re-review has been performed. The bill has been over-paid based on CMS' updated DRG 494 pricer rates for DOS 7/16/2016 – 7/18/2016 for provider #450135. CMS' DRG 494 rate of $10,097.25 @ 143% = $14,439.07. The bill was paid $14,454.08 when originally processed. Therefore, an overpayment is noted in the amount of $15.01."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2016 to July 18, 2016	Inpatient Hospital Services	$39.54	$39.54

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
   - B13 – The charge for this procedure exceeds the fee schedule allowance
   - Z710 – The charge for this procedure exceeds the fee schedule allowance
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 193 – The charge for this procedure exceeds the fee schedule allowance
   - W3 – The charge for this procedure exceeds the fee sch

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The division established that the requestor is eligible for reimbursement subject to the provisions of 28 TAC §134.404 titled Hospital Facility Fee Guideline – Inpatient. Reimbursement is calculated pursuant to 28 TAC §134.404 (f), which states, in pertinent part:

   The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 143 percent; unless

   Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

   The division establishes the total Medicare facility specific amount in this case using the *Medicare Inpatient PPS PC Pricer* as a tool. The *Medicare Inpatient PPS Pricer* efficiently identifies facility specific payment factors and adjustment. The pricer is found at www.cms.gov.

   The following illustrates the division's calculation of the total Medicare facility specific amount:

TOT DRG AMT:	Add back VBP CR *(not applicable due to conflict with Texas Labor Code)*	Add Cost Outlier *(applicable)*	Total Medicare Facility Specific Amount
$10,110.53	+ $24.87	+ $0.00	$10,135.40

   Note that a claim reduction identified as "VBP CR" on the *Medicare Inpatient PPS Pricer* was added back into the total DRG amount for this admission. "VBP CR" stands for Value-Based Purchasing (VBP) claim reduction (CR) which in Medicare is used to fund the Medicare VPB program. Medicare's VBP program was

implemented to monitor and improve quality of care provided at inpatient hospitals participating in the Medicare system. Consequently, the Medicare VBP program conflicts with existing Texas Labor Code (TLC) sections 413.0511 and 413.0512 which provide for the review and monitoring of the quality of health care provided in the Texas workers' compensation system. The fee rule for inpatient hospital services contains a conflict provision which explains that the Texas Labor Code in such instances takes precedence:

28 TAC §134.404 (d)(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

For this reason, the VBP CR amount does not apply. The VBP claim reduction amount was therefore added back in because it does not apply to inpatient hospital services provided in the Texas Workers' Compensation system.

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 494. The services were provided at TX Health Fort Worth. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $10,135.40. This amount multiplied by 143% results in a MAR of $14,493.62.
3. The total recommended payment for the services in dispute is $14,493.62. The insurance carrier has paid $14,454.08. The amount due to the requestor is $39.54. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $39.54.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $39.54, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	7/27/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.